November 11, 2008

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REPORT IN THE CARE OF
Geoffrey Crowther
DOB: [redacted]
ACCT #19337

I initially saw Mr. Crowther in the office on September 26, 2005. This man, aged in his middle 50's, is employed doing heavy work for the railroad company. He complains of pain at the ulnar border of his left wrist, pain in the left thumb, intermittent episodes of numbness and tingling in the hands with radiation of pain up the forearms. He describes his symptoms as having gone on for several years and gradually worsening. Although he was doing some supervision as well as some heavy work, it still bothered him quite a lot. He presented for my evaluation of this.

The examination on September 26th demonstrated a healthy appearing man of his stated age. Alert, oriented, answered my questions clearly and appropriately. No acute distress. He had full range of movement elbow, forearm, wrist and digits bilaterally other than the left thumb. There was is restricted movement at the metacarpal phalangeal joint from 30 less than neutral extension to 45 of flexion compared with 0 to 70 on the opposite side. He had pain at the ulnar border of the left wrist at the extremes of forearm rotation but not with the extremes of flexion and extension. TFC grind test was equivocal. No instability of the wrist or digital joints including the LT and distal RUJ of the left wrist. There is tenderness at the ulnar carpal interval of the left wrist, but not the right one. There was no tenderness elsewhere about the left wrist. There was tenderness in the region of the MP joint of the left thumb, but no tenderness at its IP joint or the basal joint of the thumb. No tenderness in any of these joints on the right side. Light touch sensibility was normal in the medial, ulnar, radial sensory distribution bilaterally. Median and ulnar nerve innervated intrinsics are normal bilaterally. Extrinsic wrist and digital flexors and extensors are normal bilaterally. Phalen's maneuver caused pain in the left forearm as did the median nerve compression test on the left side.

Three X-ray views of the left wrist were taken showing ulnar plus one half mm on the left side, otherwise the wrist films are negative. PA and lateral x-ray of the thumb metacarpal phalangeal joint shows advanced arthritic change there with deviation of the thumb tip in an ulnar direction. There is large surrounding peripheral osteophytes and marked joint space narrowing.

I reviewed with Mr. Crowther the findings and recommended to him that he undergo an electrical test for the median nerve at the left wrist. I also suggested that he undergo injection therapy to the ulnocarpal interval of the left wrist. Finally, with respect to his thumb MP joint, I told him that anything less than an operation is likely to only have a very short lived beneficial effect for him.

He was to have the electrical testing done and then think about what he wished to do after that. If the ENM was positive, I would offer him an injection for carpal tunnel syndrome for the ulnocarpal interval of the left wrist. I told him that if he wanted to try injection therapy for the thumb MPJ, it was all right with me, but I thought this was unlikely to last very long given the clinical and radiographic appearance there. Likely to eventually require arthrodesis metacarpal phalangeal joint left thumb, question CTR. He understood that the alternatives for surgical treatment for the MP joint of the thumb were arthrodesis vs arthroplasty, and since he still did quite a lot of heavy work with this hand, arthrodesis was the better choice.

The patient was next evaluated in the office on October 4, 2005 by Mr. Pacitti. The electrical testing that Mr. Pacitti performed was normal. The patient was injected into the left thumb metacarpal phalangeal joint area at the site of maximum tenderness. He again saw Mr. Pacitti on December 3, 2005. At that time, Mr. Pacitti felt that his symptoms may have been attributable to cervical radicular pain.

I next saw the patient on October 18, 2006. He had been evaluated by Dr. R. Scott Cowan in our offices. Dr. Cowan felt that he had multiple level cervical disc disease. I gather that Dr. Cowan and Mr. Pacitti had discussed the possibility of surgical intervention, but the patient had declined.

I again saw Mr. Crowther on December 20, 2006. At that time, he was found to have X-ray evidence of arthritis in the metacarpal phalangeal joint of his left thumb.

In February of 2007, I performed an arthrodesis of the metacarpal phalangeal joint of his

left thumb. His wound primarily. In mid April 2007, when I evaluated him, he had findings consistent with solid arthrodesis at that joint.

I have not seen Mr. Crowther since April 13, 2007.

It should be noted that at the time that I initially saw him, Mr. Crowther already had advanced arthritis in the metacarpal phalangeal joint of that thumb.

With respect to your questions about whether or not his left thumb problem is attributable to a specific injury, I do not believe that it is. With respect to the questions whether his left thumb arthritis is a result of what he does at work, I cannot state whether it is or isn't.

Signed and sworn to under the pains and penalties of perjury, this ____ day of November 2008.

Yours sincerely,

Steven M. Wenner, M.D.

SMW/hh

GEOFFREY CROWTHER 05/07/1951

199336.0

November 30, 2008 WENNER/mmc:

ADDENDUM TO REPORT IN THE CARE OF:

Geoffrey Crowther
Account #: 199336
DOB :

On his job Mr. Crowther performs heavy use of his hands as a railroad worker. He aggravated the arthritis of the metacarpophalangeal joint of his left thumb in using it for his work related duties.

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